VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 6, 2012

Ms. Ursula Margazano, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401

Provider #: 475014

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 5, 2012 .** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING _____ B. WING _____	C 06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted by the Division of Licensing & Protection on May 2, 2012 and completed on June 5, 2012. There were regulatory violations related to the complaint survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on complainant interview, staff interviews and record review, the services provided by the facility did not meet professional standards of quality for 1 resident in the sample regarding failing to monitor a change in the resident's clinical status. (Resident #1) Findings include: Per record review on 5/2/12, the staff nurse failed to assess and /or monitor a change in Resident #1's clinical status after s/he received a report from the licensed nursing assistant (LNA) that the resident was having an 'anxiety attack.' Per record review, on 4/15/12 at approximately 7:30 P.M. the LNA reported to the staff nurse that Resident #1's daughter reported to her that her mother was having an 'anxiety attack.' The LNA reported this to the nurse who was in the process of receiving the 'change of shift report' from the day nurse. The nurse instructed the LNA to obtain the vital signs for Resident #1. The LNA took the vital signs and reported back to the nurse that the resident's pulse was 131 and the oxygen saturation (02 sat) was 60% (while on 4 liters of	F 281	**The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.** **F-281** The facility maintains that it monitors changes in resident's clinical status. **How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :** Education to the nurse involved - monitor all residents that have a change in clinical status. **DON, ADON, SDC, &/or designee** **How will the facility identify other residents having the potential to be affected by the same deficient practice? :** All residents are potentially affected by this alleged deficient practice.	**6-27-12** **On-going**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 6/26/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 continuous oxygen) and that the resident was having chest pain/difficulty breathing. The nurse went to the resident's room and reported that the resident's daughter was yelling at her to 'call 911!' Per nursing documentation on 4/15/12 at 20:45, there was no evidence that s/he reassessed the resident's vital signs, including the oxygen saturation rate. The nurse documented in the progress notes that s/he: elevated the head of the bed, gave a neb (nebulizer) treatment and 'notified (the) supervisor trying to stabilize (the) resident before calling the MD.' While the nurse was attempting to reach the on-call physician, the resident's daughter called 911. The ambulance arrived within minutes and the ambulance personnel documented on their pre-hospital care report that upon arrival, the patient complained of chest pain, was sitting up in bed with 0.5 albuterol by neb (nebulizer) at 6L/M (oxygen at 6 liters per minute) not moving any air and gasping for breath. The 02 saturation rate was 55%. Per interview with the Director of Nursing Services (DNS) on 5/2/12 at 12:30 P.M. s/he confirmed that s/he would 'expect an 02 sat of 60% to be reported to the physician immediately.' S/he also confirmed that the staff nurse was educated after the facility investigation that 'the family knows the resident more than we do and if family felt that the resident should go to the ER [emergency room] to call 911 and get the resident to the hospital-call the doctor after the 911 call is made.' Per interview with the staff nurse on 5/2/12 at 1:00 P.M., s/he confirmed that s/he had spent between 10 and 20 minutes more in change of shift report after the LNA reported	F 281	**What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :** Education to all nurses - monitor all residents who have a change in clinical status. **DON, ADON, SDC, &/or designee** **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? :** 5 random audits/week per unit of residents with a change in clinical status X 4 weeks through clinical stand-up meeting (concurrent review) to insure change is monitored. Results reported at Action Team and QA meetings with changes made as appropriate. **DON, ADON, SDC, &/or designee** F281 POC accepted 7/5/12 DCrittenden RN \ Pmc	7-2-12 7-3-12

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F 281	Continued From page 2 Resident #1's 'anxiety attack.' S/he also confirmed that s/he had not taken the pulse or checked the resident's oxygen saturation rate after the LNA reported an 02 sat of 60%. S/he also confirmed that s/he had not called 911 because s/he was waiting to speak with the physician to receive 'transfer orders first.' Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.		The facility maintains that it provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on complainant interview, staff interviews and record review, the facility failed to provide one resident (Resident # 1) the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being regarding seeking prompt medical attention for a resident in acute distress. Findings include: Per record review on 5/2/12, the staff nurse failed to assess and /or monitor a change in Resident #1's clinical status after s/he received a report from the licensed nursing assistant (LNA) that the resident was having an 'anxiety attack.' Per	F 309	**How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice? :** Education to the nurse involved - immediately evaluate any resident that has a change in clinical status, evidenced by time documentation. **DON, ADON, SDC, &/or designee** **How will the facility identify other residents having the potential to be affected by the same deficient practice? :** All residents are potentially affected by this alleged deficient practice.	**6-27-12** **On-going**

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F 309	Continued From page 3 record review, on 4/15/12 at approximately 7:30 P.M. the LNA reported to the staff nurse that Resident #1's daughter reported to her that her mother was having an 'anxiety attack.' The LNA reported this to the nurse who was in the process of receiving the 'change of shift report' from the day nurse. The nurse instructed the LNA to obtain the vital signs for Resident #1. The LNA took the vital signs and reported back to the nurse that the resident's pulse was 131 and the oxygen saturation (02 sat) was 60% (while on 4 liters of continuous oxygen) and that the resident was having chest pain/difficulty breathing. The nurse went to the resident's room and reported that the resident's daughter was yelling at her to 'call 911!' Per nursing documentation on 4/15/12 at 20:45, there was no evidence that s/he reassessed the resident's vital signs, including the oxygen saturation rate. The nurse documented in the progress notes that s/he: elevated the head of the bed, gave a neb (nebulizer) treatment and 'notified (the) supervisor trying to stabilize (the) resident before calling the MD.' While the nurse was attempting to reach the on-call physician, the resident's daughter called 911. The ambulance arrived within minutes and the ambulance personnel documented on their pre-hospital care report that upon arrival, the patient complained of chest pain, was sitting up in bed with 0.5 albuterol by neb (nebulizer) at 6L/M (oxygen at 6 liters per minute) not moving any air and gasping for breath. The 02 saturation rate was 55%. Per interview with the Director of Nursing Services (DNS) on 5/2/12 at 12:30 P.M. s/he confirmed that s/he would 'expect an 02 sat of	F 309	**What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? :** Education to all nurses - Immediately evaluate any resident that has a change in clinical status, evidenced by time documentation. **DON, ADON, SDC, &/or designee**	7-2-12
			How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? : 5 random audits/week per unit of residents with a change in clinical status X 4 weeks through clinical stand-up meeting (concurrent review), to insure that immediate evaluation of a resident with a change in clinical status is performed, as evidenced by time documentation. Results reported at Action Team and QA meetings with changes made as appropriate. **DON, ADON, SDC, &/or designee**	7-3-12
			F309 POC accepted 7/5/12 DChittenden RN PMC	

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